terminate such coverage, in the following circumstances:

(i) The enrollee is no longer eligible for coverage in a QHP through the Exchange;

(ii) Non-payment of premiums for coverage of the enrollee, and

(A) The 3-month grace period required for individuals receiving advance payments of the premium tax credit has been exhausted as described in §156.270(g); or,

(B) Any other grace period not described in paragraph (b)(2)(ii)(A) of this section has been exhausted;

(iii) The enrollee's coverage is rescinded in accordance with §147.128 of this subtitle;

(iv) The QHP terminates or is decertified as described in §155.1080; or

(v) The enrollee changes from one QHP to another during an annual open enrollment period or special enrollment period in accordance with §155.410 or §155.420.

(c) *Termination of coverage tracking and approval.* The Exchange must—

(1) Establish mandatory procedures for QHP issuers to maintain records of termination of coverage;

(2) Send termination information to the QHP issuer and HHS, promptly and without undue delay in accordance with §155.400(b).

(3) Require QHP issuers to make reasonable accommodations for all individuals with disabilities (as defined by the Americans with Disabilities Act) before terminating coverage for such individuals; and

(4) Retain records in order to facilitate audit functions.

(d) *Effective dates for termination of coverage.* (1) For purposes of this section, reasonable notice is defined as fourteen days from the requested effective date of termination.

(2) In the case of a termination in accordance with paragraph (b)(1) of this section, the last day of coverage is—

(i) The termination date specified by the enrollee, if the enrollee provides reasonable notice;

(ii) Fourteen days after the termination is requested by the enrollee, if the enrollee does not provide reasonable notice; or

(iii) On a date determined by the enrollee's QHP issuer, if the enrollee's QHP issuer is able to effectuate termination in fewer than fourteen days and the enrollee requests an earlier termination effective date.

(iv) If the enrollee is newly eligible for Medicaid, CHIP, or the BHP, if a BHP is operating in the service area of the Exchange, the last day of coverage is the day before such coverage begins.

(3) In the case of a termination in accordance with paragraph (b)(2)(i) of this section, the last day of coverage is the last day of the month following the month in which the notice described in §155.330(e)(1)(ii) is sent by the Exchange unless the individual requests an earlier termination effective date per paragraph (b)(1) of this section.

(4) In the case of a termination in accordance with paragraph (b)(2)(ii)(A) of this section, the last day of coverage will be the last day of the first month of the 3-month grace period.

(5) In the case of a termination in accordance with paragraph (b)(2)(ii)(B) of this section, the last day of coverage should be consistent with existing State laws regarding grace periods.

(6) In the case of a termination in accordance with paragraph (b)(2)(v) of this section, the last day of coverage in an enrollee's prior QHP is the day before the effective date of coverage in his or her new QHP.

[77 FR 18444, Mar. 27, 2012, as amended at 77 FR 31515, May 29, 2012]

Subparts B Through G [Reserved]

Subpart H—Exchange Functions: Small Business Health Options Program (SHOP)

SOURCE: 77 FR 18464, Mar. 27, 2012, unless otherwise noted.

§155.700 Standards for the establishment of a SHOP.

(a) *General requirement.* An Exchange must provide for the establishment of a SHOP that meets the requirements of this subpart and is designed to assist qualified employers and facilitate the enrollment of qualified employees into qualified health plans.

(b) *Definition.* For the purposes of this subpart:

Group participation rule means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

§ 155.705 Functions of a SHOP.

(a) *Exchange functions that apply to SHOP.* The SHOP must carry out all the required functions of an Exchange described in this subpart and in subparts C, E, and K of this part, except:

(1) Requirements related to individual eligibility determinations in subpart D of this part;

(2) Requirements related to enrollment of qualified individuals described in subpart E of this part;

(3) The requirement to issue certificates of exemption in accordance with § 155.200(b); and

(4) Requirements related to the payment of premiums by individuals, Indian tribes, tribal organizations and urban Indian organizations under § 155.240.

(b) *Unique functions of a SHOP.* The SHOP must also provide the following unique functions:

(1) *Enrollment and eligibility functions.* The SHOP must adhere to the requirements outlined in §§ 155.710, 155.715, 155.720, 155.725, and 155.730.

(2) *Employer choice requirements.* With regard to QHPs offered through the SHOP, the SHOP must allow a qualified employer to select a level of coverage as described in section 1302(d)(1) of the Affordable Care Act, in which all QHPs within that level are made available to the qualified employees of the employer.

(3) *SHOP options with respect to employer choice requirements.* With regard to QHPs offered through the SHOP, the SHOP may allow a qualified employer to make one or more QHPs available to qualified employees by a method other than the method described in paragraph (b)(2) of this section.

(4) *Premium aggregation.* The SHOP must perform the following functions related to premium payment administration:

(i) Provide each qualified employer with a bill on a monthly basis that identifies the employer contribution, the employee contribution, and the total amount that is due to the QHP issuers from the qualified employer;

(ii) Collect from each employer the total amount due and make payments to QHP issuers in the SHOP for all enrollees; and

(iii) Maintain books, records, documents, and other evidence of accounting procedures and practices of the premium aggregation program for each benefit year for at least 10 years.

(5) *QHP Certification.* With respect to certification of QHPs in the small group market, the SHOP must ensure each QHP meets the requirements specified in § 156.285 of this subchapter.

(6) *Rates and rate changes.* The SHOP must—

(i) Require all QHP issuers to make any change to rates at a uniform time that is either quarterly, monthly, or annually; and

(ii) Prohibit all QHP issuers from varying rates for a qualified employer during the employer's plan year.

(7) *QHP availability in merged markets.* If a State merges the individual market and the small group market risk pools in accordance with section 1312(c)(3) of the Affordable Care Act, the SHOP may permit a qualified employee to enroll in any QHP meeting the following requirements of the small group market:

(i) Deductible maximums described in section 1302(c) of the Affordable Care Act; and

(ii) Levels of coverage described in section 1302(d) of the Affordable Care Act.

(8) *QHP availability in unmerged markets.* If a State does not merge the individual and small group market risk pools, the SHOP must permit each qualified employee to enroll only in QHPs in the small group market.

(9) *SHOP expansion to large group market.* If a State elects to expand the SHOP to the large group market, a SHOP must allow issuers of health insurance coverage in the large group market in the State to offer QHPs in such market through a SHOP beginning in 2017 provided that a large employer meets the qualified employer requirements other than that it be a small employer.